STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G442	A. BUILDING 00 B. WING	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	402 EWING LN JEFFERSONVILLE, IN 47130

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W0000	This visit was a post certification revisit (PCR) to the investigation of complaint #IN00104904 completed on March 16, 2012. Complaint #IN00104904: Corrected. Unrelated deficiencies cited. Dates of Survey: May 22, 23, and 24, 2012. Facility Number: 000956 Provider Number: 15G442 AIMS Number: 100244760 Surveyor: Dotty Walton, Medical Surveyor III. The following deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/4/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W0120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, record review and interview, for 1 of 3 sampled clients (B), the facility failed to ensure the day services providers were apprised of changes in client B's programming and medical status regarding an episode of choking. Findings include: Client B was observed eating lunch at her day program on 5/23/12 at 11:50 AM until 12:30 PM. She was monitored by staff and ate canned fruit cocktail instead of fresh fruit. Review of investigations/incident reports on 5/22/12 at 3:15 PM indicated an episode of choking with client A on 5/11/12. The incident report review indicated client A was attending a dance on 5/11/12 at 5:00 PM and choked on a piece of cauliflower. The report by facility staff #4 indicated client B was eating and when she choked on the "small piece of cauliflower," staff #4 did the Heimlich Maneuver "on her to bring it up." A second review of facility	W0120	**Corrective Action: (Specific)** The Program Coordinator will train the workshop staff on Client B's diet plan. Client B will be monitored by the PC/designees during the meal at the workshop and the home to ensure the dining plan is being followed. The Program Coordinator will inform the workshop staff of any choking incident that occurs on all clients. **How others will be identified: (Systemic)** Before being admitted to the workshop, all Program Coordinators train the workshop staff on all client dining plans. The Program Coordinators inservice all revisions of dining with workshop staff. **Measures to be put in place:** The Program Coordinator will train the workshop staff on Client B's diet plan. Client B will be monitored by the PC/designees during the meal at the workshop and the home to ensure the dining plan is being followed. The Program Coordinator will inform the workshop staff of any choking incident that occurs on all clients. **Monitoring of Corrective Action:** The Operations Manager or the Director of Supervised Group Living will	06/23/2012

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	investigation/incident reports was done on 5/23/12 at 3:30 PM. The review indicated an investigation of a incident wherein client B had choked on an orange slice at her day program on 12/02/11 during lunch. The investigation's interview with day program skills trainers on 12/02/11 at 10:30 AM stated client B "came up to her [skills trainer #9] pointing at her throat, choking. She initiated the Heimlich and the orange slice was removed whole." Skills trainer #10 stated "[Client B] was eating and did not chew her orange well and the Heimlich was initiated by [skills trainer #9]. The orange came up looking whole still." The client's PC/Program Coordinator/Qualified Developmental Disabilities Professional-designee staff #1 was interviewed on 12/2/11 at 1:00 PM. PC #1 stated: "[Client B's] food was cut into small pieces as required in the diet plan. However, [client B] had snuck the orange so it had not been properly cut up appropriately." The investigative summary concluded client B had placed an orange in her lunch container along with her modified consistency meal. The client's lunch was to be checked for appropriate consistency foods, her food was to be cut into small pieces and she was to be prompted to chew her food thoroughly. Skills Trainer Manager staff #8 was		ensure that all diet plans are reviewed by workshop staff. The Operations Manager or the Director of Supervised Group Living will ensure that the workshop is notified of any client choking episode.	

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	interviewed on 5/23/12 at 12:05 PM. The Manager indicated client B had taken/stolen caffeine sodas belonging to workshop staff from the staff refrigerator and consumed them. Skills trainers #9 and #10 were interviewed on 5/23/12 at 12:15 PM. No workshop staff were aware client B had an episode of choking on raw cauliflower on 5/11/12. The workshop's copy of client B's dining plan (reviewed 5/23/12 12:05 PM) was dated 12/02/11. Review of client B's record on 5/23/12 at 1:25 PM indicated a dining plan dated 5/11/12 which listed the most recent choking episode. The record review indicated LPN #10 had made more dietary consistency recommendations on 5/18/12 of "no raw vegetables." The day program did not have this information. The record review indicated a 5/18/12 Individual Support Plan/ISP meeting which was held at the workshop. PC #1 did not share the new dining plan or information regarding the 5/11/12 choking incident with client B at the ISP meeting with workshop staff. Interview with Qualified Developmental Disabilities Professional staff #2 on 5/23/12 at 4:25 PM indicated the day services providers should have been apprised of the latest choking incident with client B.			

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	This deficiency was cited on 3/16/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, for 1 of 3 sampled clients (B), the facility failed to ensure an episode of choking was fully investigated to ascertain the actual events to facilitate corrective measures. Findings include: Review of investigations/incident reports on 5/22/12 at 3:15 PM indicated an episode of choking with client A on 5/11/12. The incident report review indicated client A was attending a dance on 5/11/12 at 5:00 PM and choked on a piece of cauliflower. The report by facility staff #4 indicated client B was eating and when she choked on the "small piece of cauliflower," staff #4 did the Heimlich Maneuver "on her to bring it up." A second review of facility investigation/incident reports was done on 5/23/12 at 3:30 PM. The review indicated an investigation of a incident wherein client B had choked on an orange slice at her day program on 12/02/11 during lunch. "...[Client B] had snuck the orange so it had not been properly cut up	W0154	**Corrective Action: (Specific)** The Quality Assurance staff will be retrained that all alleged violations (which includes choking) will be thoroughly investigated. Recommended corrective measures to prevent violations, such as choking, will be included in the investigations. The Quality Assurance staff will thoroughly investigate Client B choking on a small piece of cauliflower. Recommended corrective measures will be included in the investigation. **How others will be identified: (Systemic)** When investigations are concluded by the Quality Assurance Team, recommendations for preventive measures will be stated. **Measures to be put in place:** The Quality Assurance staff will be retrained that all alleged violations (which includes choking) will be thoroughly investigated. Recommended corrective measures to prevent violations, such as choking, will be included in the investigations. The Quality Assurance staff will thoroughly investigate Client B choking on a small piece of cauliflower. Recommended corrective measures will be included in the investigation. **Monitoring of Corrective Action:** The Executive Director	06/23/2012

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	appropriately." The investigative summary concluded client B had placed an orange in her lunch container along with her modified consistency meal. The client's lunch was to be checked for appropriate consistency foods, her food was to be cut into small pieces and she was to be prompted to chew her food thoroughly. The 5/23/12 3:30 PM review of investigations indicated the investigation of the 5/11/12 choking incident with client B. The 5/11/12 (reviewed by the administrator on 5/18/12) investigation summary of evidence indicated "[Client B] was at workshop for an after hours event and when she took a bite of cauliflower she didn't completely chew up the food and she got choked. Staff immediately performed the Heimlich and [client B] spit out the cauliflower. All staff were following [agency] policy and procedure during the incident." The investigative "conclusion and findings: It is the conclusion of the investigation committee that [client B] choked on a piece of cauliflower while she was at workshop." There was no mention of client B's history of choking, her history of taking food which was inconsistent (whole orange) with her diet order, her need to wear her dentures when eating, and her need to be monitored and prompted during		will review all investigations to ensure preventive measures are included in all completed investigations.	

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	meals/snacks. There was no information in the investigation which indicated how big the piece of cauliflower was, if the client had taken the food with/without permission or staff supervision. The investigation did not indicate if the client was wearing her dentures (she was edentulous and had full dentures), how much supervision she had or if she was being prompted to chew slowly and cut up her cauliflower into small pieces during the episode. There were no recommendations listed in the investigation to implement as corrective measures for the choking with client B. Interview with Quality Assurance Staff #1 on 5/23/12 at 3:30 PM indicated the investigation started 5/11/12, was reviewed by the administrator on 5/18/12, and this was the extent of the investigation at the time of the survey. This deficiency was cited on 3/16/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			

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W0159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview, for 1 of 3 sampled clients (B), the client's Qualified Developmental Disabilities Professional/QDDP failed to integrate, coordinate, and monitor client B's active treatment program in regards to a choking episode. Findings include: Please refer to W120 for the QDDP's failure to coordinate with the day services provider and notify them of client B's choking episode on 5/11/12 and give them the most recent dining plans. Please refer to W154 for the QDDP's failure to ensure client B's 5/11/12 choking episode was fully investigated to ascertain the actual events and corrective measures were implemented immediately to protect client B while assessments were being conducted. Please refer to W189 for the failure of the QDDP to monitor the facility staff for training regarding client B's dietary changes related to choking and how to implement dietary guidelines regarding	W0159	**Corrective Action: (Specific)** The Program Coordinator will retrain the Program Coordinator that workshop staff are to be inserviced on all client dining plans and revisions. The Program Coordinator and the QMRP will be retrained that immediate preventive measures are put in place to prevent further choking episodes. The Nurse and the QMRP will retrain all the staff on all client dining plans, including client B. **How others will be identified: (Systemic)** Before being admitted to the workshop, all Program Coordinators train the workshop staff on all client dining plans. The Nurses and the Program Coordinators train all staff on dining plans of all clients before admission to the home. The Nurses and the Program Coordinators train staff on any dining plan revision on the clients. **Measures to be put in place:** The Program Coordinator will retrain the Program Coordinator that workshop staff are to be inserviced on all client dining plans and revisions. The Program Coordinator and the QMRP will be retrained that	06/23/2012

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	cutting sandwiches into small pieces as needed. 9-3-3(a)		immediate preventive measures are put in place to prevent further choking episodes. The Nurse and the QMRP will retrain all the staff on all client dining plans, including client B. **Monitoring of Corrective Action:** The Program Coordinator, the QMRP, or the Nurse will monitor the staff to ensure that staff follow all dining plans for all the clients.	

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W0189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review and interview, for 1 of 3 sampled clients (B), the facility failed to ensure the direct contact staff had been adequately trained to prepare client B's meal in a small pieces after an episode of choking. Findings include: During observations at the facility on the evening of 5/22/12 from 5:15 PM until 7:00 PM, the evening meal was observed. The food was on the table and the clients were eating as staff #3 was cutting up client B's food. The food consisted of a baked hamburger pattie on a bun, potato wedges, raw tomatoes, sliced pickles, and sliced raw onion. Staff #3 stated the hamburger "was cut into 16 pieces." The pieces appeared to be large (1 inch by inch by 1/2 inch thick) so LPN #10 was consulted by the surveyor. LPN #10 directed staff to cut each piece of the hamburger again into smaller pieces. Client B finished her meal and placed her dentures into her pocket. Review of investigations/incident reports on 5/22/12 at 3:15 PM indicated an	W0189	**Corrective Action: (Specific)** The Nurse and the Program Coordinator will retrain all the staff on all client dining plans, including client B, and all revisions of client diet plans, including client B. **How others will be identified: (Systemic)** The Nurses and the Program Coordinators train all staff on dining plans of all clients before admission to the home. The nurses and Program Coordinators train staff on any dining plan revisions on the clients. **Measures to be put in place:** The Nurse and the Program Coordinator will retrain all the staff on all client dining plans, including client B, and all revisions of client diet plans, including client B. **Monitoring of Corrective Action** The Program Coordinator, the QMRP, or the Nurse will monitor the staff to ensure that staff follow all dining plans for all the clients.	06/23/2012

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	episode of choking with client B on 5/11/12. The incident report review indicated client B was attending a dance on 5/11/12 at 5:00 PM and choked on a piece of cauliflower. The report by facility staff #4 indicated client B was eating and when she choked on the "small piece of cauliflower," staff #4 did the Heimlich Maneuver "on her to bring it up." A second review of facility investigation/incident reports was done on 5/23/12 at 3:30 PM. The review indicated an investigation of a incident wherein client B had choked on an orange slice at her day program on 12/02/11 during lunch. The client's PC/Program Coordinator/Qualified Developmental Disabilities Professional-designee staff #1 was interviewed on 12/2/11 at 1:00 PM. PC #1 stated: "[Client B's] food was cut into small pieces as required in the diet plan. However, [client B] had snuck the orange so it had not been properly cut up appropriately." Review of client B's record on 5/23/12 at 1:25 PM indicated a dining plan dated 5/11/12 which indicated the client's food was to be cut into small pieces, sandwiches into 16 pieces, and no raw fruit, canned fruit only after the 12/02/11 orange incident. The record review indicated a follow up appointment with client B's doctor on			

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	5/15/12. The doctor indicated "progressive dysphagia for solids, choked on cauliflower earlier this week. Has been choking intermittently, endures heartburn daily." The doctor recommended the following: "Diet restrictions: canned fruit (no fresh fruit) sandwiches and meat into 16 pieces. Eat slowly...." The record review indicated LPN #10 had made more dietary consistency recommendations on 5/18/12 of "no raw vegetables." Interview with LPN #10 and PC #1 on 5/22/12 at 6:25 PM indicated client B's hamburger required extra cutting and she should not have raw vegetables (pickles, onions) or raw fruit (tomatoes) until she had further assessments of her chewing/swallowing capabilities. 9-3-3(a)			